Strategic planning and execution in rehabilitation using the bio-psycho-social approach

Þessi grein var upprunalega skrifuð sem hluti af alþjóðlegu samstarfi, Health Policy across Europe, sem er ástæða þess að hún er skrifuð á ensku.

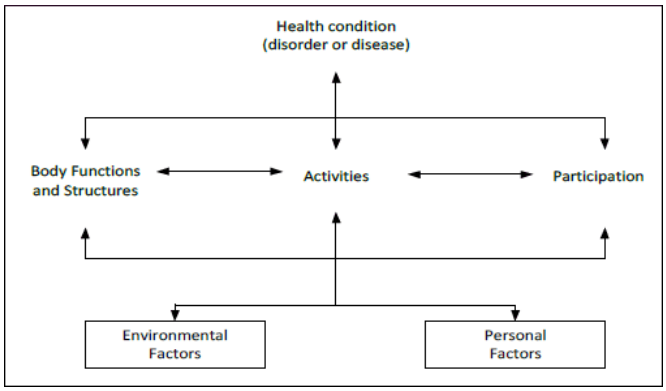
Ása Dóra Konráðsdóttir B.Sc. sjúkraþjálfun, M.Sc stjórnun heilbrigðisþjónustu, SEP frá LBS.

Abstract

Common problems exist when it comes to strategic planning and execution in the business world as well as in the health care system. If one wants to be successful in this area it is important to be aware of those problems when innovating and implementing new ideas as well as being familiar with successful ways.

There are a lot of new knowledge in rehabilitation that needs to be implemented into clinical practice. One has been the knowledge of the bio-psycho-social approach using the ICF system, which involves by other means that more emphasize is on individual activity and participation outcomes, not just the impairment level.

A lot of research and papers have been written about the ICF model but very few on the experience of implementing it into clinical practice. The experience described in this article shows that it is easier said than done to incorporate the model into clinical practice. Therefor it is important to give more attention to the development of effective ways when the ICF system is incorporated into clinical practice.



Introduction

Many countries have good legislation and related policies on rehabilitation, still there are some common problems in development, implementation and delivery of these policies. The use of the bio-psycho-social approach with the help of the International Classification of Functioning, Disability and Health (ICF) is used as an example in this article to describe some of those problems.

Lack of strategic innovation and execution in rehabilitation

In many countries strategic planning is lacking which results in uneven distribution of service capacity and infrastructure as well as lack of agency responsible to administer, coordinate, and monitor the service. Other common problems are inadequate health information systems and communication strategies. This can result in low rates of participation in rehabilitation as well as complex referral systems. In return this can limit access to the service and result in inappropriately referral and unnecessary medical consultations. Absence of engagement with the people receiving the service when it comes to design, implementation, and evaluation of rehabilitation program was also seen as a common problem in many countries (WHO, 2011).

The knowledge from the business world is also aware of problems when it comes to execution of a strategy. Here are some facts that show that we need to pay a close attention to this part if one wants to be successful in getting important knowledge into practise:

Less than 10% of strategies effectively formulated are effectively executed
5% of the workforce understands the strategy
25% of managers have incentives linked to strategy
85% of executive teams spend less than one hour a month discussing strategy
37% of revenue targets are lost due to misalignment
60% of organizations don't link budgets to strategy
(Kaplan, R.S., Norton, D.P., 2004)

The importance of the bio-psycho-social approach in rehabilitation and the measurement of functioning

An assessment of functioning is always the starting point of a patient and goal oriented rehabilitation process. Important part of this assessment is the measurement of activity and participation outcomes, the individual's performance across a range of areas (WHO, 2011). This is in accordance with Nordenfelt statement; a quantified measure of degree of impairment related to separate diseases or injuries cannot give an answer to the question that concerns the overall disability of a person. Nordenfelt further stated:

"In general, a specific impairment can have an effect on one person which is so different from the effect of the same impairment on another person that the impairment itself cannot function as a reasonable criterion for decisions in the medical insurance system.

A person impairment may but need not lead to an activity limitation and an activity limitation may but need not lead to a participation restriction" (Nordenfelt, 2008).

The internal processes of the individual, the goals and the surrounding nature are also important element. An individual's participation restriction (or activity limitation) cannot be understood, without reference to the individual own view of his situation and own goals. Therefor it is not possible to make a description or assessment of the individual disability unless his voice is heard and involved in the description and evaluation (Solli, 2007).

Integration of ICF in assessment of functioning

Function is the key word in ICF as it looks at the individual in the community in which he lives, regardless of what caused the impairment (WHO, 2001). As a result ICF provides a multi-perspective approach and serves as very helpful tool in connection to the bio-psycho-social approach.

ETV mynd 1 hér sem heitir The framework of International Classification of Functioning, Disability and Health (ICF)

EUMASS (the European union of social security doctors) used the ICF system to develop a core set for functional assessments in disability benefit claims i.e. for long-term restrictions in work participation. It contains 20 categories from ICF – 5 from body functions, and 15 from activities/participation This core set was intended to be used by medical doctors in the evaluation of rights for long term benefits (Brage S, Donceel P, Falez F., 2008). One idea that has been put forward by Konráðsdóttir (2011) and further described in The Handbook of Vocational Rehabilitation and Disability Assessment (2015) chapter about Work disability assessment, is to use the EUMASS core set early on in the rehabilitation process. That way you can work systematically with important functional factors through the rehabilitation process to receive a maximal functional level before a decision is made on the individual functional level.

At the same time specific ICF tools have been developed that can be integrated into the Rehab-cycle as a problem solving approach and can be useful for a multidisciplinary team. By using existing ICF Core sets and ICF Qualifiers these ICF Tools allow the description of the function of the individual and should support a common understanding of functioning (Rauch, A., Cieza, A., Stucki, G., 2008).

Implementing the ICF system into clinical practice, some thoughts.

Here I list some common thoughts, questions and problems that arose when integrating the ICF into clinical practice.

How do we use the standard language of the ICF system as a common knowledge in a multidisciplinary team and clinical practice?

The ICF system provides a standard language and framework for the description of health and health-related states. Each code in the system is followed by an international explanation about what it means. But is it so easy to understand and use it in clinical practice? Let´s have a look at explanation for one code in the chapter Body functions and structure.

„General mental functions of periodic, reversible and selective physical and mental disengagement from one's immediate environment accompanied by characteristic physiological changes"

Does anybody know what function is beeing described? Is it practical to use this standard language in a clinical practise? For those that didnt come up with the answer this is a description of the code b134, Sleep functions.

How do we differentiate between different parts of the ICF system when it comes to a overall measurement of function?

One thing that is common with all developed core sets is that they are using codes from different parts of the system. In the EUMASS core set for example we have both b and d parts. The EUMASS core set includes both b710 and d455. Individual with frozen shoulder will therefor show problem in b710, Mobility of joint functions. That problem is probably going to affect the function in d455, Hand and arm use (see table 1).

Should we then double the problem in an overall measurement of function or try to differentiate between the b and the d part?

Table 1. Example of b and d part of the ICF system

b710 Mobility of joint functions	**d455 Hand and arm use**
Functions of the range and ease of movement of a joint	Performing the coordinated actions required to move objects or to manipulate them by using hands and arms, such as when turning door handles or throwing or catching an object

Use of measurement tools

First it is important to keep in mind that when you have more than one team working with same protocol for example an overall assessment you have to be able to compare the function of the individual between different teams and different time zone.

As an example we could easily see that two different teams looking at the same problem could decide to use different measurement tools as a guide to qualify different codes (table 2). Will we get the same result from those two teams when using the qualifiers to get a clear picture of the functional loss of that individual?

Table 2. Two different approaches in measuring activity level of an individual with back pain.

Team 1-measurement of activity level	**Team 2-measurement of activity level**
Berg Balance Scale	Bending forward and backward
Timed Up and Go	Trunk twisting
Timed Sit to Stand	Transfers
Functional Reach Test	Walking (sit, stand, laying down)

How do we match different measurement tools to different codes without losing their meaning?

An update of the linking rules within the ICF was published in 2005. Four new linking rules were established, three rules to link health-status measures and one to link technical and clinical measures and interventions (Cieza et al, 2005). Still in clinical practice this is not always so easy to do.

There are many tools in clinical practice that are designed to answer the question if an individual fulfills a sudden clinical

criteria. In the psychological field for example we have quite a lot of instruments that are very well studied and widely accepted. An example is GAD-7, Generalized Anxiety Disorder. Higher score has been connected to the severity of anxiety and has been shown to correlate with disability and functional impairment (see link: http://www.mdcalc.com/gad-7-general-anxiety-disorder-7/). But if we are using measurement tools like this that can be connected to more than one code, how do we incorporate them to the codes within the ICF system without losing their overall meaning?

How can we get professionals that are trained in finding problems start to look at possibilities?

To quantify the functional impairment the use of the qualifiers in the ICF is recommended, a qualifier states the magnitude or severity of the problem in question. They also serve as a sitemap to identify the impairment and that way support the understanding of function. This is also very helpful when a multidisciplinary team is working together in the assessment, it enables all team members to get a common language (Rauch, A., Cieza, A., Stucki, G., 2008).

Looking at the explanation of using the qualifiers they refer to an impairment, limitation, restriction or barrier, see table 3.

Table 3. Qualifiers within the ICF system

Qualifier	Explanation
0	NO problem
1	MILD problem
2	MODERATE problem
3	SEVERE problem
4	COMPLETE problem

As one can see the explanation for each qualifier is in connection to the extent of the problem/functional loss of the individual involved. But how does that relate to strengths or can be served as a sitemap to tell us what this individual can do, not only what he cannot do?

Conclusion

It is known that there are some common problems in strategic planning and execution in the business world as well as in the health care system. It is important to be aware of those problems if one wants to be successful in finding new ideas and put them into practice. It is the author experience that this is particularly important to keep in mind if an idea involves new approach or different thinking like putting the ICF system into clinical pratctice.

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